VIRGINIA:

BEFORE THE BOARD OF MEDICINE

IN RE: RODGER A. FRASER, M.D.
License No.: 0101-053053

ORDER OF SUMMARY SUSPENSION

In accordance with Section 54.1-2408.1 of the Code of Virginia (1950), as amended ("Code"), the Virginia Board of Medicine ("Board") met on February 8, 2002, to receive and act upon investigative information indicating that Rodger A. Fraser, M.D., may have violated certain laws relating to the practice of medicine in the Commonwealth of Virginia. The matter was presented by Emily Wingfield, Assistant Attorney General. Also participating in the meeting were William L. Harp, M.D., Executive Director of the Board; Karen W. Perrine, Deputy Executive Director of the Board; and Lorraine McGehee, Deputy Director of Administrative Proceedings; and Assistant Attorney General Roscoe Roberts, counsel for the Board. Upon hearing the evidence presented, the Board determined that the continued practice of Dr. Fraser constitutes a substantial danger to the public health and safety, in that:

1. On or about November 20, 2001, Patient A, accompanied by her boyfriend, presented to Dr. Fraser at the Commonwealth Women's Clinic, Falls Church, Virginia, for an elective abortion. Patient A's last monthly period was documented on her intake form as "Aug. 01 9/2" (sic). Dr. Fraser recorded that his bimanual examination confirmed an 11 to 13 week-sized uterus. Without performing an appropriate pre-operative evaluation, Dr. Fraser initiated the abortion. Dr. Fraser stated to the Department of Health Profession's investigator ("Department's investigator") that the fetal parts he removed were more developed than an 11 or 12 week-old fetus; instead, they were comparable to that of an 18 to 20 week-old fetus.

2. During the procedure, Dr. Fraser perforated Patient A's uterus multiple times, damaging her bowel and causing her to hemorrhage. Dr. Fraser instructed the staff to call paramedics for transport to a local hospital.

3 At no time did Dr. Fraser speak to Patient A or her boyfriend, nor did Dr. Fraser explain to Patient A or her boyfriend the reason for her transport to the hospital.

4. Patient A was taken to INOVA Fairfax Hospital via ambulance. Dr. Fraser abandoned Patient A when he sent her to the hospital with insufficient documentation or guidance explaining Patient A's condition. Dr. Fraser failed to directly communicate with any of the hospital's physicians until after the hospital staff took multiple affirmative and active steps to contact Dr. Fraser. Specifically, Dr. Fraser stated in his interview with the Department's investigator that he informed an emergency room nurse that he was sending in a patient, but failed to speak to a physician on duty and failed to sufficiently explain the patient's condition. According to hospital staff, the medical record he sent with Patient A was illegible. Shortly after transfer, attempts by the hospital staff to contact Dr. Fraser regarding Patient A's condition were unsuccessful. When Dr. Fraser eventually contacted a resident later that night, the hospital had already determined the severity of the injury. During this conversation, Dr. Fraser reported to the resident a larger than expected fetus, and stated that he saw an undamaged loop of bowel after removing several fetal parts. This information was used to re-confirm the hospital's findings. Until Dr. Fraser returned the hospital's calls, all communication by Dr. Fraser to any doctors at the hospital was through third parties.

5. Patient A was admitted to INOVA Hospital and underwent an emergency exploratory laparotomy, which revealed a large gaping defect in the low posterior uterus and a mesenteric injury to the sigmoid colon with resultant vascular compromise. Further, an ossified fetal head with a biparietal

diameter of 5.6 cm was extracted from the uterus. Due to the extent of her injuries, Patient A required a supracervical hysterectomy and a Hartmann's procedure with end colostomy.

6. Upon review of the evidence, Dr. Fraser made numerous inconsistent statements and medical record entries. Specifically:

- In Dr. Fraser's letter to the Board, he stated that he introduced himself to Patient A, explained the procedure, and examined her chest and heart. However, in his interview with the Department's investigator, Dr. Fraser said he did not speak to Patient A because she did not speak English. The investigator confirmed the fact that Patient A could not speak English, and confirmed that neither she nor her boyfriend spoke with Dr. Fraser
- In his letter to the Board, Dr. Fraser stated that no ultrasound was taken because the machine was either broken or out of film. However, in his interview with the Department's investigator, Dr. Fraser said that a nurse did not take an ultrasound before the procedure because she did not have time. He later stated that he performed an ultrasound on Patient A during the procedure. When asked about the identity of the nurse, he could not remember her name, and he believed that she was no longer with the clinic.
- In his letter to the Board, Dr. Fraser stated that a staff member from the clinic followed Patient A to the hospital; however, he did not identify the staff member. Further, the hospital records do not indicate that a staff member was present at the hospital's emergency room.
- In his initial exam, Dr. Fraser noted the age of the fetus at 11 weeks on the physical examination form, yet when the hospital was contacted, Dr. Fraser estimated the age of the fetus to be 15 to 20 weeks. Also, on the Gross Pathology Report form, Dr.

Fraser noted that the placenta was the only product of conception examined and identified and the tissue appeared normal. Further, he recorded that the tissue was consistent with a complete abortion of either an eight week or eighteen week-sized fetus, and Patient A was sent to the recovery lounge in good condition.

- In his letter to the Board and his statement to the Department's investigator, Dr. Fraser stated that the cause of Patient A's bleeding was placenta previa and that he confirmed this finding by ultrasound. The clinic's records contain no reference to placenta previa and Dr. Fraser did not report this condition to staff or physicians at the hospital.

7. Dr. Fraser failed to list his practice at Commonwealth Women's Clinic, Falls Church, Virginia, as a primary or secondary address on his Virginia Practitioner Profile.

ORDER

WHEREFORE, it is hereby ORDERED that the license of Rodger A. Fraser, M.D., to practice medicine and surgery in the Commonwealth of Virginia be, and hereby is, SUMMARILY SUSPENDED, simultaneously with the institution of proceedings as stated in the February 8, 2002, Notice of Formal Hearing and Statement of Particulars.

Upon entry of this Order, the license of Rodger A. Fraser, M.D. will be recorded as suspended and no longer current. Pursuant to Section 54.1-2920 of the Code, upon entry of this Order, Dr. Fraser shall forthwith give notice, by certified mail, of the suspension of his license to practice medicine to all patients to whom he is currently providing services. Dr. Fraser shall cooperate with other practitioners to ensure continuation of treatment in conformity with the wishes of the patient. Dr. Fraser shall also notify any hospitals or other facilities where he is currently granted privileges and any health insurance companies, health insurance administrators or health maintenance organization currently reimbursing him for any of the healing arts.

Pursuant to Section 2.2-4023 of the Code, the signed original of this Order shall remain in the custody of the Department of Health Professions as a public record, and shall be made available for public inspection and copying upon request.

FOR THE BOARD

William L. Harp, M.D.
Executive Director
Virginia Board of Medicine

ENTERED: 2/8/02